NOTICE OF ACTION
About Your Treatment Request
"Modify"

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Address]
[City, State Zip]
[Name of Medical Home]

HWLA Member Identification #: ***[insert number]***
DMH IS #: ***[insert number]***

RE: ***[****insert type of service requested]*

(Insert name of requesting provider or clinic) has asked *(insert name of Referral Center)* to approve *(insert type of treatment requested).* We cannot approve this treatment as asked. We will instead approve: *(Insert what you are approving)*

(Insert a clear and concise explanation of the reasons for the decision; the program requirements that support the action; a description of the criteria or guidelines used).

NOTE: If you cannot read or understand this letter, call DMH Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

As a DMH Healthy Way LA (HWLA) member, you have the following appeal rights:

1. You have the right to appeal this decision. That means that if you do not agree, you can have us review the decision to see if it is correct. If you want to appeal this decision, you must ask for the appeal within **60 days** of the date of this Notice of Action letter. It can take up to 45 days for DMH Patients' Rights to decide your appeal.

   If you think that waiting this long could put your life or health at serious risk or put at serious risk your ability to get back the most function possible, ask for an expedited appeal. DMH Patients' Rights will decide an expedited appeal within 3 working days.

To ask for a regular or expedited appeal, call DMH Patients' Rights at (213) 738-4949. If you have problems hearing or speaking, use TTY/TDD at (800) 735-2929. We will help you with your appeal. You can also ask for your appeal by writing or sending a fax to:

DMH Patients' Rights
550 S. Vermont Avenue
Los Angeles, CA 90020
Fax: (213) 365-2481

2. You have the right to speak for yourself during the appeal or to choose another person to act for you. That person may be a relative, friend, advocate, doctor, lawyer or someone else**.**

3. You may send written comments, documents, records and other information about your appeal. You may also ask for a hearing in person or by telephone where you can give the reasons why you do not agree and examine and cross examine witnesses.

4. Except in some limited cases, you will be able to review your case file before and during the appeal process.

5. If, after we make our decision, you are still unhappy, you may ask for a State Fair Hearing. You may ask for a State Fair Hearing **after** you have completed the HWLA appeal process and have received a decision letter.

If you have questions, concerns, want to give information about your appeal, or want to ask for a hearing in person or on the telephone with the person deciding your appeal, call DMH Patients' Rights at (213) 738-4949, or use TTY/ TDD at 1 (800) 735-2929.

This notice does not affect any other HWLA services.

Sincerely,

_____
(Name of Provider of Services or CAU Reviewer)

c: DMH Patients' Rights
Requesting Provider